

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-019950
STATE FILE NUMBER

Registration District No. 317 Primary Registration District No. 500 Registrar's No. 1404

DATE AMENDED

INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT
MEDICAL CERTIFICATION
BY AFFIDAVIT OF

AMENDED FILED JUN 6 1961

| | | | |
|--|---|---|--|
| 1. PLACE OF DEATH a. COUNTY <u>St Louis</u> | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MO</u> b. COUNTY <u>St Louis</u> | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Lemay</u> | | Length of stay in 1b <u>20 yrs</u> | c. CITY OR TOWN <u>Lemay</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>732 Cumberland</u> | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | d. STREET ADDRESS (If outside, give location) <u>732 Cumberland</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>Samuel H Splean</u> | | | 4. DATE OF DEATH Month Day Year <u>May 19 1961</u> |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>White</u> | 7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH <u>Sept 2 1877</u> |
| 9. AGE (last birthday) <u>83</u> | | IF UNDER 1 YEAR Months Days | IF UNDER 24 HR Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired clerk</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Chemical</u> | 11. BIRTHPLACE (City and state or country) <u>St Louis Mo</u> |
| 12. CITIZEN OF WHAT COUNTRY <u>USA</u> | | 13a. FATHER'S NAME <u>Simon Splean</u> | |
| 13b. MOTHER'S MAIDEN NAME <u>Not known</u> | | 14. NAME OF HUSBAND OR WIFE <u>Caroline</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u> | | 17. INFORMANT Address <u>Joseph Splean 732 Cumberland</u> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Arrhythmia</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Arteriosclerotic Heart Dis</u> DUE TO (c) _____ | | | INTERVAL BETWEEN ONSET AND DEATH <u>1 year</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) | | | PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/> | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) | |
| 20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year | | 20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 20f. CITY, TOWN, OR LOCATION COUNTY STATE | |
| 21. I attended the deceased from <u>Jan 3, 1952</u> to <u>5/18/61</u> and last saw her/him alive on <u>5/18/61</u> Death occurred at <u>330 A</u> m on the date stated above, and to the best of my knowledge, from the causes stated. | | | |
| 22a. SIGNATURE (Degree or title) <u>Harold Franklin M.D.</u> | | 22b. ADDRESS <u>16 Hampton Valley</u> | 22c. DATE SIGNED <u>5/19/61</u> |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 23b. DATE <u>May 22, 1961</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Mt Hope</u> | 23d. LOCATION (City, town, or county) (State) <u>St Louis County Mo</u> |
| 24. FUNERAL DIRECTOR ADDRESS <u>John L Ziegenhein & Sons 7027 Gravoie</u> | | 25. DATE RECD. BY LOCAL REG. <u>5-19-61</u> | 26. REGISTRAR'S SIGNATURE <u>John M. Murphy M.D.</u> |

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Donald King

Licensed Embalmer No. 2867

P. O. Address St Jannis

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.